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SOCIO-ECONOMIC AND HEALTH CONDITIONS OF SOME MAJOR TRIBES IN ANDHRA PRADESH

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I. Abstract

Despite number of initiatives for improving living conditions of the tribals, the progress is not up to the mark. The forests are depleting at faster rate, though the government records do not reflect the reality at ground level. These forests are in no way sustaining food requirements of forest dwellers through their traditional means of hunting and gathering. Mostly they are dependent on agriculture either as cultivators or agriculture labourers. They are malnourished, poor, largely illiterate and rank miserably low in all sorts of health indicators despite of their wealth of traditional knowledge of keeping healthy. Their literacy levels are not adequate to compete with the general population and at the same time they decline to do any work in their native places. In this paper, an attempt is made to bring out general economic conditions, health issues and role of NGOs. Some of these issues are discussed based on two research works: one on Yerukula tribe, a Dispersed Tribal Group (DTG) inhibiting in Prakasam, Nellore and Chittoor districts of Andhra Pradesh and a baseline survey (for CARE-STEP) of tribes inhibiting in jungles in North coastal districts of Andhra Pradesh.

Key Words: Yerukula, Health Conditions, Coastal Andhra, NGOs, Sub Plan funds

II. Introduction:

The proportion of tribal population has been increasing from census to census. In the Constitution, the backward ethnic groups categorised under Scheduled Castes (SCs) and Scheduled Tribes (STs) to facilitate them to reserve jobs, seats in educational institutions, etc. Scheduled Tribes basically live in forests.

The tribal groups in India vary in features as geographical isolation, simple technology and conditions of living, general backwardness to the practice of animism, tribal language, physical features, etc. The criteria was neither clearly formulated nor systematically applied. One set of criteria was used in one context and quite different in another context. The result is that the list includes groups and communities strikingly different from each other, not only size of the population but also the level of technology and other characteristics. Indian anthropologists havebeen aware of a lack of fit between what the discipline defines as tribe and what they are obliged to describe as tribes (Xaxa, 1999). Further, there are instances of exclusions and unqualified inclusions. There are many communities whose self-image is that of being tribals and/or who are recognised as tribals by their neighbours but who have not been listed as STs. On the other hand there are communities who are not considered as tribals by their neighbours but who are in the list. For instance the Swanglas who are Brahmans in Himachal Pradesh are treated as a scheduled tribein the statute. In 1991 census 67.8 million persons were enumerated a ST; around 600 community names have been listed, but many of them aresub-tribes or synonyms (Burman, 2003). Mukherjee also reported similar problems in Madhya Pradesh. Census of India 1961 and 1991 listed 58 and 46 tribes respectively in Madhya Pradesh. But there are about 70 tribes in total because some 20 tribal groups due to various reasons have been left out (Mukherjee, 2003).

In India, sizeable tribal population live in Andhra Pradesh state.. There are 33 different tribal groups in the state with a population of 4.2 million. A large chunk of tribal population is mainly concentrated in the nine scheduled districts: Srikakulam, Vizianagaram, Visakhapatnam, West Godavari, East Godavari, Warangal, Khammam, Adilabad and Kurnool (Subramanyam, 2003).

III. Data sources:

The data on Yerukula is obtained from the baseline survey conducted for Yerukula Tribal Development Plan and the data on north coastal districts of AP is taken from CARE STEP baseline survey. The Yerukula data is collected from secondary data and primary survey of 68,154Yerukula households, group discussions with various tribal leaders and NGOs (The fieldwork was conducted during 1999, in Nellore, Chittoor and Prakasam districts). The household and village data was collected through the structuredschedules. All the households of major Yerukula inhabited villages were contacted with schedules in the three districts. Among the tribal inhabited villages (based on census list), Yerukula

inhabited villages were identified based on the enquiries with Yerukulas in the Region.

In another study (CARE-STEP) 6000 households were surveyed in the tribal districts of north coastal Andhra Pradesh. The tribal areas in four north coastal districts of Andhra Pradesh, Viz., Srikakulam, Vizianagaram, Visakhapatnam and East Godavari, are categorised into following four strata: 1) Plain mandals which are easily accessible, 2) Plain mandals which were not easily accessible, 3) Hilly mandals which were easily accessible and, finally, 4) Hilly mandals which were not easily accessible. First stage sampling unit was the mandal. The mandals were selected from the above mentioned strata in the respective districts, based on tribal populations. In the second stage 200 villages ar selected. From each of the mandals around 30 households are selected. Thus the total sample was around 6000 households

Tribes of North Coastal Andhra Pradesh: The predominant tribes in the Coastal Andhra region are Konda Reddy, Koya Dora, Bhagata, Konda Dora, Porja, Jatapu and Savara. The Primitive Tribal Group (PTG) which figured in the study are Konda Reddy, Khond, Gadaba, Porangi porja and Savara. The family size was 4.6 persons on an average. Some families found to have more members as seen in the Tables 1&2.

Table 1: Distribution of Households by Family size and Access

S.No	Family Size	Plain ac-accessible	Plain in-accessible	Hilly ac-accessible	Hilly in-accessible	Total
1	1-2	10.95	10.41	8.75	9.22.	9.42
2	3-4	42.61	42.64	39.03	38.68	39.80
3	5-7	42.72	43.97	47.02	46.43	45.85
4	8-10	3.40	2.64	4.97	5.28	4.62
5	10 and above	0.33	0.33	0.22	039	0.31
	Total	100.00 (913)	100.00 (605)	100.00 (2252)	100.00 (2311)	100.00 (6081)

Source: primary data

Table 2: Distribution of Households by Family Size, by Tribe Group (percentage)

S. No	Family Size	PTG	NPTG	Total
1	1-2	9.33	9.48	9.42
2	3-4	38.81	40.41	39.80
3	5-7	46.60	45.38	45.85
4	8-10	4.88	4.46	4.62
5	10 andabove	0.39	0.27	0.31
Total		100.00 (2337)	100.00 (3744)	100.00 (6081)
Average family size		4.67	4.61	4.63

Source: Centre for Economic and Social Studies, Begumpet, Hyderabad.

Economic Aspects: Economic conditions of the tribal groups are discussed in the section. Since Independence, under Green Revolution, several irrigation projects were constructed and thousands of acres of land were brought under cultivation in the project area. Thus agriculture has become main occupation to the general population and there has been great demand for agricultural labour. About six months in a year, the poor and landless Yerukulas who were once depending on forest, fishing, etc., has gradually taken toagricultural labour. Now agriculture labour has become main occupationof Yerukulas in the project area. As per baseline survey, about eighty three per cent of the Yerukulas were engaged in agriculture as labourers. Thus the hunting and food collecting Yerukula has become an agriculture labourer. The occupational structure of Yerukulas in the project area is furnished in Table 3.

Table 3: The Present occupational pattern of Yerukulas in the Project area according to the base line survey conducted is furnished below:

S.No	Occupation	Percentage
1	Agriculture labour	83.40
2	Collection and selling of fire wood	5.60
3	Fishing	4.90
4	Cultivation	2.00
5	Construction labour, transport labour, etc	0.20
6	Services.	0.60
7	Mining, Transport labour, etc.	3.30

The Yerukulas living in the urban and semi-urban areas were mostly depending on rickshaw pulling, working as sweepers in municipalities and scavenging here and there. The survey revealed that around Rs. 5000 to Rs. 6000 was spent for food and household maintenance in the project area. The expenditure on social and religious ceremonies, on purchase of medicines ranged from around Rs. 100 to Rs.400. The expenditure on alcohols, repayment of old debts was relatively less. The expenditure pattern of Yerukulas is furnished in the Table 4.

Table 4: Expenditure Pattern of Yerukulas in the Project Area

S.No	Annual Expenditure (Rs.)	Districts			
		Nellore	Chittoor	Prakasam	Total
1	Food	4,991.11	4,964.06	6,059.87	5,191.70
2	Clothing	817.49	837.34	1,171.45	890.67
3	Social and Religious Ceremonies	466.94	592.00	832.39	560.54
4	Alcohols	72.34	354.94	765.71	194.33
5	Purchase of medicines	465.59	641.31	625.58	529.93
	Total	6,813.50	7,548.23	10,027.3	7,328.20

Source: Centre for Economic and Social Studies, Begumpet, Hyderabad

Their expenditure on alcohol was quite High. Many Yerukulas were defending on moneylenders for credit. They borrowed money for the purpose of domestic, health, and repayment of old debts, investment on income yielding pursuits. Out of total surveyed households of 68,154 only 8,533 were indebted which worked out to 12.5 per cent. The survey revealed that more than 80 per cent of the indebted Yerukula families borrowed from moneylenders only. The average debt position of the indebted Yerukula households in the project area was Rs. 2080 per annum. The purpose and source of borrowing as per the survey (1998-99) by the Yerukulas in the project area are furnished in the Table 7.

Very few households availed credit from formal sources such as Girijana Co-opertaive Corporation Limited (GCC). Compared to other tribal populated districts such as north coastal Andhra Pradesh, the dependence and availability of Non Timber Forest Produce (NTFP) was minimal. That is why GCC played very limited role here. However, despite of number of other government programmes, majority of them depend on moneylender for their major credit needs.

Table 5: Indebtedness Among Yerukulas in the Project Area

S.No	Source of bor-rowing	Purpose of borrowing						
		Household ex-penditure R	Repay-ment of debts R	Health R	Inves-tment R	Functions/ Ceremo-nies R	Others R	Total C
1	Nationalised banks	32.70	17.30	3.10	30.60	0.00	16.30	1.10
2	Gramina banks	53.40	2.30	3.80	20.60	1.50	18.30	1.50
3	Money lenders	58.90	16.20	21.50	0.80	2.60	0.10	88.00
4	Relatives/ friends	63.40	0.50	7.70	11.90	15.50	1.00	2.30
5	GCC	16.70	16.70	8.30	50.00	8.30	0.00	0.10
6	Others	60.50	0.70	14.70	20.30	1.00	2.90	6.90
	Total	64.20	14.50	20.20	3.10	2.70	0.70	100.00
	Total Number	5,006	1,240	1,725	268	231	63	8,533

Note: R: Centre for Economic and Social Studies, Begumpet, Hyderabad

Table 6: Distribution of Workers (14+) by Main Occupation and Access

S. No	Occupation	Plain accessible	Plain inaccessible	Hilly accessible	Hilly inaccessible	Total
I .	Cultivation	32.71	36.75	50.93	55.72	48.66
2.	Agricultural labour	46.91	53.67	38.40	32.99	39.11
3.	Casual labour in non-agriculture	13.42	4.35	5.22	5.43	6.43
4.	Livestock rearing/ Fishing	0.82	1,56	0.79	0.83	0.89
5.	Minor forest Produce	1.68	0.14	0.81	0.67	0.82
6.	Government em-ployee	2.64	1.83	2.20	2.68	2.41
7.	Employee in pri-vate firm	0.77	1.02	.0.69	0.74	0.75
8.	Business	0.41	0.48	0.51	0.48	0.48
9.	Others	0.64	0.20	0.45	0.46	0.46
	TOTAL	100.00 (2198)	100.00 (1472)	100.00 (5541)	100.00 (5668)	100.00 (14879)

Figures in brackets are absolutes.

Source: Centre for Economic and Social Studies, Begumpet, Hyderabad.

IV. Health Aspects

The government structure as it exists today is unable to meet the health needs of the people in the tribal areas. When someone falls sick, the immediate government health personnel available at the village is the ANM. On records, there is one ANM for every 10 villages. Often she is not available in the village. Most sub-centres are poorly equipped and function from dilapidated buildings, resulting in poor performance and delivery of services As per the government rules for tribal areas, one PHC should cater to a population of 20000. However in practice, very few PHCs satisfy this. Though health facilities are provided in tribal areas, accessing these facilities is another main problem for majority of the tribals. Particularly north coastal Andhra tribes live in hilly terrain and forest areas. Physical distance seems to be less. But to travel that small distance, they have to climb up and down the hillocks. As a result, it is difficult to take the seriously ill person to the nearby health facility. Further health workers rarely visit such areas. Moreover the tribal areas have specific (endemic) health problems such as malaria, flourosis, gastro- enteritis, malnutrition etc.

Table 7: Details Relating to Delivery by Tribe Group (Percentages)

S.No.	Details	PTG	NPTG	TOTAL
Place where the child was born				
I .	Home	90.89	92.46	91.85
2.	Sub-centre	0.48	--	0.19
3.	PHC	1.44	1.06	1.20
4.	Private clinic	1.44	1.06	1.20
5.	District hospital	5.76	5.43	5.56
6.	Others	--	--	--
	TOTAL	100.00 (417)	100.00 (663)	100.00 (1080)
Assistance during delivery				
I.	Family members	55.88	53.70	54.54
2.	Government doctor	8.39	6.64	7.31
3.	Private doctor	4.32	2.41	'3.15
4.	ANM.	6.00	6.49	6.30
5.	Dai	24.70	29.41	27.59
6.	Others	0.72	1.36	1.11
	TOTAL	100.00 (105)	100.00 (163)	100.00 (1080)

Source: primary data

Though these households approach private or government allopathic hospitals for major ailments, substantial number of them depends on locally available medical personnel such as herbalist and traditional practitioners. Veena Bhasin in her study among six tribal groups explains the curative process of sick person. The strategy a person chooses for treatment of his or her illness or that of a relative depends on personal experiences and preferences. The tribal response to health problems reveals a multiple and simultaneous usage of home remedies and multiple therapy depending on the cultural logic based on medicine of body fluids and supernatural dimensions (Bhasin, 2003). Therefore due to the poor health infrastructure in the study areas, still majority depends on local resources for their health needs. In Yerukula inhabited villages, particularly in Nellore and Chittoor districts, significant number of traditional medicine men provides health services. These locally available private practitioners are mostly qualified in non-allopathic systems or persons running a practice without any qualification (Duggal & Vadair, 1995).

As shown in the Table 10, delivery is generally at home assisted by family members, locally available untrained or in some cases trained birth attendants. Though some studies confirm that midwife assisted home births are safe (Patel & Sharma, 2000), the tribal households prefer home deliveries in Andhra Pradesh. For instance, Konda Dora do not take their women to the hospital for delivery; it is possible that in the hospital the woman has to stay alone in the maternity room with the midwife visiting now and then, whereas in her village, she is surrounded by her elders and friends who comfort her and give her confidence to go through the ordeal.

91.85 per cent of child births took place at home invariably with the assistance of family members and dais. Almost all deliveries in respect of women of Khond and Bhagata tribes, Konda Dora, Jatapu, and Poija took place at home. This exposes the pregnant women to a great deal of risk. Although the deliveries attended to at home were relatively few in East Godavari it was no cause for complacency because the deliveries conducted there at home were also high. Health workers complained that it was highly difficult to motivate tribals to take the pregnant women to dispensaries. Part of the explanation for this lies in the difficult terrain in which they live. Often the difficult task of taking the pregnant women from a household located in an inhospitable terrain to a far off dispensary was compounded by the rains that sever the villages from the main land. The present system ostensibly cannot change in a few months or years. Habits die-hard and it may be more so in case of tribals. The financial incentive given to pregnant women to visit local hospitals was also found to be of no great help (C.S.Murty N. Subba Reddy & Babu, 2004). NFHS surveys also revealed the same as shown in the Table 11. Even in other health indicators IMR, TFR, Immunization etc, their condition is poor compared to the general population. Even the recently conducted Mid Term Evaluation of 11th Five Year Plan, Less than 60 percent of the deliveries were institutional in

Srikakula, Vizianagaram and Visakhapatnam districts of Coastal Andhra. The tribal population is relatively high in these districts (Manoj Panda et al ., 2011).

Health problems are a direct outcome of poverty, government policies that have adversely affected local livelihoods - high land alienation amongst tribals, threatened traditional agricultural practices, absence of forest rights and growing indebtedness (Yakshi, 2002). Over the past 10 years, livelihood systems in the tribal areas have witnessed rapid changes under the impact of government policies and development programmes. Subsidy induced agriculture promoted actively by the government has had a negative impact on local agriculture, which is a major source of livelihood.Changing cropping pattern due to the introduction of commercial crops like tobacco and cotton replacing traditional food crops have adversely impacted on tribal's health eroded their food and nutritional security. Their dietary habits have changed from primarily millet and pulse base to rice base, resulting in deficiency of essential micronutrients, calories and proteins and declining immunity levels.

While there is a rich body of traditional healing practices, a growing dependence on allopathic medicine coupled with loss of medicinal plants have undermined the importance of traditional systems. As noted earlier, numerous local medicinal plants and herbs are effective as preventives as also proven cures. However these are being abandoned, thus increasing susceptibility to disease. Mitra explains that the ecological conditions drive them to be a part of belief system. Day-today unexplainable experiences have led the tribal people into believing in other than the material visible world. Generally the tribal people are found to establish a close relationship with the spiritual world either by controlling or overpowering the spirit by enchanting (Mitra, 2004). In the tribal society belief system and health (illness) are interrelated. For instance, Bhils are scared of evil spirits because they cause harm and illness. Tribals try to appease them in various ways (Jain & Agrawal, 2005). In Rajasthan, still people seek traditonal priests to heal the illnesses caused by supernatural powers in tribal population of Rajasthan (Nagda, 2004). In some places treatment to diseases caused by sorcery (Mukherjee, 2004). In tribal community, illness and the consequent treatment is not always an individual and familiar affair, but the decision about the nature of treatment may be taken at the community level. In case of some specific diseases, not only the diseased person but also the total village community is affected.Health and treatment are very much connected with the environment. The traditional health care system and treatment are based on their deep observation and understanding of nature. The Tribal healer used, different part of plants not only for treatment, but also even for population control (Nagda, 2004).

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